Michigan Department of Health and Human Services

Practitioner Special Services Prior Approval - Request/Authorization Completion Instructions

The MSA-6544-B must be used by Medicaid enrolled providers to request provider services that require prior authorization (PA) (e.g. out-of-state care and genetic testing).

MDHHS requests that the MSA-6544-B be typewritten to facilitate processing. A Word fill-in enabled version of this form can be downloaded from the MDHHS website www.michigan.gov/medicaidproviders >> Policy and Forms >> Forms. For information on required modifiers, documentation, and appropriate quantity amounts, refer to the following documents:

- Standards of Coverage portion of the provider-specific chapters of the Medicaid Provider Manual.
- Billing & Reimbursement for Professionals Chapter of the Medicaid Provider Manual.
- Provider-specific databases on the MDHHS website. www.michigan.gov/medicaidproviders >> Billing and Reimbursement >> Provider Specific Information.
- For more detailed information on procedure codes refer to CHAMPS – External Links – Medicaid Code and Rate Reference.

Completion of this form is as follows:

Box 1	MDHHS Use Only
Box 22	Indicate whether this is the first request for services or if this is a renewal request for ongoing services
Box 24	Enter a complete description of the services, procedures, lab test, etc. requested
Box 25	Enter the HCPCS Procedure Code.
Box 26	Enter the applicable HCPCS Modifier.
Box 27	Enter the quantity of the services requested. If an injectable drug is requested, indicate the number of billing units requested.
Box 28	Enter the dates for which the requested procedure or service will take place.
Box 29	Enter the beneficiary's primary and secondary diagnoses or the CSHCS qualifying diagnosis (list both the code and description)
Box 30	Any additional remarks regarding the request should be listed in this box such as verbal authorization date, retroactive date of service if being requested. Provide other insurance coverage for services requested.
Box 31	Check each box that corresponds to documentation included in the request. No request should leave all boxes unchecked.
Box 32	Must be completed for all requests.

Form Submission

PA request forms and required documentation for all eligible Medicaid beneficiaries must be mailed or faxed to:

MDHHS - Medical Services Administration
Program Review Division
P.O. Box 30170
Lansing, Michigan 48909

Fax Number: (517) 335-0075

The status of a PA request may be reviewed in CHAMPS. For additional questions, contact the MDHHS - Medical Services Administration, Program Review Division via telephone at **1-800-622-0276.**

Michigan Department of Health and Human Services

PRACTITIONER SPECIAL SERVICES
PRIOR APPROVAL – REQUEST/AUTHORIZATION

1. PRIOR AUTHORIZATION NUMBER (MDHHS USE ONLY)

The provider is responsible for eligibility verification. Approval does not guarantee beneficiary eligibility or payment.

2. Reason for PA Request:

☐ OUT OF STATE CARE ☐ CLINICAL PROCEDURE ☐ OFFICE ADMINISTERED DRUG OR BIOLOGICAL ☐ SURGERY

☐ OTHER _____

3. PROVIDER'S NAME (LAST, FIRST, MIDDLE INITIAL)	4. NPI NUMBER	5. PHONE NUMBER
6. PROVIDER'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		7. FAX NUMBER

8. BENEFICIARY'S NAME (LAST, FIRST, MIDDLE INITIAL)	9. SEX ☐ **M** ☐ **F**	10. BIRTH DATE	11. MIHEALTH CARD NUMBER
12. BENEFICIARY'S ADDRESS (NUMBER, STREET, APT./LOT NUMBER, CITY, STATE, ZIP)			

13. HOSPITAL/ FACILITY NAME	14. HOSPITAL/ FACILITY NPI

15. REFERRING/ORDERING PHYSICIAN'S NAME (LAST, FIRST, MIDDLE INITIAL)	16. NPI NUMBER	17. PHONE NUMBER
18. REFERRING/ORDERING PHYSICIAN'S ADDRESS (NUMBER, STREET, STE., CITY, STATE, ZIP)		19. FAX NUMBER
20. CONTACT NAME		21. CONTACT PHONE NUMBER - -

22. ☐ INITIAL REQUEST ☐ RENEWAL REQUEST

23. LINE NO.	24. DESCRIPTION OF SERVICE	25. PROCEDURE CODE	26. MODIFIER	27. QUANTITY	28. ANTICIPATED DATE(S) OF SERVICE
01					
02					
03					
04					

29. DIAGNOSES (CODES AND DESCRIPTIONS) REQUIRING THE ABOVE SERVICES.	30. ADDITIONAL REMARKS, INCLUDING OTHER INSURANCE COVERAGE ON THE DATE OF SERVICE.

31. Identify all relevant clinical documentation that has been submitted to support medical necessity: *If this is an out-of-state request, in addition to clinical documentation, include a letter of medical necessity that explains A) why services cannot be provided in state, B) what in-state services have already been exhausted, and C) the plan to transition care back to the state of Michigan.*

☐ H&P ☐ PROGRESS NOTES ☐ CONSULTATIONS ☐ LABS

☐ PATHOLOGY REPORT ☐ OPERATIVE REPORT ☐ RADIOLOGY REPORTS ☐ PHOTOS ****INCLUDE PHOTOS FOR ALL COSMETIC AND RECONSTRUCTIVE SURGERIES**

☐ DISCHARGE SUMMARY ☐ LETTER OF MEDICAL NECESSITY ☐ OTHER DIAGNOSTICS:_____

32. **PROVIDER CERTIFICATION:** THE PATIENT NAMED ABOVE (PARENT OR GUARDIAN IF APPLICABLE) UNDERSTANDS THE NECESSITY TO REQUEST PRIOR APPROVAL FOR THE SERVICES INDICATED. I UNDERSTAND THAT SERVICES REQUESTED HEREIN REQUIRE PRIOR APPROVAL AND, IF APPROVED AND SUBMITTED ON THE APPROPRIATE INVOICE, PAYMENT AND SATISFACTION OF APPROVED SERVICES WILL BE FROM FEDERAL AND/OR STATE FUNDS. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF A MATERIAL FACT MAY LEAD TO PROSECUTION UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PROVIDER'S SIGNATURE: DATE:

MDHHS USE ONLY

31. REVIEW ACTION: ☐ APPROVED ☐ DENIED ☐ RETURN ☐ NO ACTION ☐ APPROVED AS AMENDED

32. CONSULTANT REMARKS

CONSULTANT SIGNATURE AND DATE: